STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-09/09-501
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Office of Vermont Health Access (OVHA) requiring her to enroll in the Employer Sponsored Insurance Premium Assistance (CHAP-ESIA) program rather than the Catamount Health Assistance (CHAP) Plan. The petitioner argues that her employer's health insurance policy is not affordable given the costs she will bear due to a chronic health condition.

The case started at fair hearing on October 15, 2009. Evidence was taken that day. At hearing, OVHA was provided new information including notice that the employer was looking into changes to the employer-sponsored health insurance and information regarding petitioner's chronic health condition and pharmaceutical costs. OVHA was given the opportunity to review these materials. Telephone status conferences were held on November 2 and 30, 2009. OVHA stood by its decision that the employer-sponsored insurance meets the comparability provisions.

During December 2009, OVHA issued a Notice of Decision

that petitioner was over-income for the Vermont Health programs. If so, the case would be moot. A telephone status conference was held on January 4, 2010. The petitioner remains below the income eligibility levels for CHAP and ESIA, and the December Notice will be vacated. In addition, the Department was given the opportunity by January 19, 2010 to supplement their argument by addressing the Board's legal conclusions in Fair Hearing No. M-04/09-196 on petitioner's chronic condition and arguments regarding comparability.

The decision is based on the evidence adduced through the fair hearing process.

FINDINGS OF FACT

1. The petitioner lives with her husband, C.H., and their minor child. They are considered a three-person household. Their child receives Dr. Dynasaur coverage.

2. Petitioner became eligible for Vermont Health Assistance Plan (VHAP) benefits during January 2009. Petitioner had been laid-off by her employer in December 2008.

3. Petitioner has a chronic condition, ulcerative colitis.[1] To maintain her health, petitioner takes a number of medications. The Department does not dispute that petitioner has ulcerative colitis.

4. This case was triggered by a review of the changes to the household's income in July 2009. A Verification Review was sent to petitioner on July 10, 2009 seeking information from petitioner's new employer.

5. Both petitioner and her husband are employed. Petitioner is a data analyst. C.H. is the administrator for a local religious institution.

6. OVHA used a combined household income of $4,398.20 per month in determining eligibility.

7. The Department for Children and Families, Economic Services Division, sent petitioner a Notice of Decision dated July 31, 2009. Petitioner and C.H. were notified that they were over-income for VHAP and their VHAP case would close August 31, 2009.

Petitioner was informed that she was eligible for CHAP-ESIA effective September 1, 2009 but that her VHAP would continue until OVHA could complete the process of determining

[1] Ulcerative colitis is defined as a "chronic, inflammatory, and ulcerative disease arising in the colonic mucosa. . .". Merck Manual, Seventeenth Edition, 1999 at page 307.

whether the employer-sponsored plan was comparable and, if so, the amount of assistance.

C.H. was informed that he was eligible for Catamount Health Assistance Program (CHAP) but that his VHAP would continue until OVHA completed the process.[2]

8. OVHA sent petitioner a Notice of Decision requiring her to enroll in employer-sponsored insurance by September 18, 2009 for herself and C.H. OVHA noted that the premium cost was $181.72 and that OVHA would not provide any assistance towards the premium because the premium is lower than the assistance OVHA provides but that the State would pay for services not covered by the employer-sponsored plan.

9. Petitioner filed for a fair hearing on September 14, 2009. She is receiving continuing VHAP benefits.

10. Petitioner supplied a Patient History Report from her pharmacist for the period of August 7, 2008 through August 6, 2009. The total retail price of her medications was $13,383.81. Petitioner paid $6.00 during that time period for her medications.

11. Petitioner's employer provides health insurance through MVP. The coverage is 80/20 except for

[2] C.H. was notified by decision dated August 14, 2009 that his CHAP eligibility begins September 1, 2009. He has received CHAP during the pendency of this hearing.

pharmaceutical, which is 50/50. Petitioner is concerned that she will be unable to afford her medications. Petitioner estimates that her medications will cost $13,000.00 per year. Under her employer's health plan, petitioner would be responsible for $6,500.00 of the cost.

12. Both petitioner and her husband are paid twice per month. Petitioner earns $2,500.00 per month. Her husband ordinarily earns $2,191.20 per month.[3] To determine their countable income, both petitioner and her husband receive the $90.00 standard employment deduction and they receive the dependent care deduction of $200.00 ending with countable income of $4,311.20 per month. Their countable income is under 300 percent of the Federal Poverty Limit (FPL).

ORDER

OVHA's decision is reversed.

REASONS

The petitioner disagrees with OVHA's requirement that she enroll in her employer's health insurance plan (CHAP-ESIA) rather than CHAP. Petitioner suffers from ulcerative colitis, a chronic condition. Petitioner faces large

[3] Her husband normally works 88 hours per pay period but his hours can fluctuate.

expenses for medications because her employer's plan only covers half the expenses; she anticipates facing $6,500 in costs. Because OVHA does not include ulcerative colitis in the chronic conditions they cover for wrap-around services; she cannot avail herself of this cost-saving in either CHAP or CHAP-ESIA.

Her case raises questions whether her employer's plan is comparable and whether her chronic condition should be excluded from wrap-around services.

Statutory and Regulatory Background

The Legislature first enacted CHAP to provide health insurance coverage to uninsured individuals who do not qualify for Medicaid or VHAP but whose income is less than 300 percent of the FPL. The Legislature added a requirement that individuals enroll in employer-sponsored insurance (ESI) in certain situations. 33 V.S.A. § 1974. The medical programs created by the Vermont Legislature are remedial programs.

The Legislature specified that the above requirement be for "approved" employer health sponsored health insurance plans. The pertinent sections at 33 V.S.A. § 1974(c) state:

1) For the purposes of this subsection:

(A) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

. . .

(3) The premium assistance program under this subsection shall provide a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual, with greater amounts of financial assistance provided to eligible individuals with lower household income and lesser amounts of assistance provided to eligible individuals with higher household income. Until an approved employer-sponsored plan is required to meet the standard in subdivision (4)(B)(ii) of this subsection, the subsidy shall include premium assistance and assistance to cover cost-sharing amounts for chronic care health services covered by the Vermont health access plan that are related to evidence-based guidelines for ongoing prevention and clinical management of the chronic condition specified in the blueprint for health in section 702 of Title 18 . . .

(4) In consultation with the department of banking, insurance, securities, and health care administration, the agency shall develop criteria for approving employer-sponsored health insurance plans to ensure the plans provide comprehensive and affordable health insurance when combined with the assistance under this section. **At minimum, an approved employer-sponsored insurance plan shall include:**

(A) covered benefits to be substantially similar, as determined by the agency, to the benefits covered under Catamount Health; and

(B)(i) until January 1, 2009 or when statewide participation in the Vermont blueprint for health is achieved, appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont blueprint for health, and in accordance with the standards established in section 702 of Title 18;

(ii) after statewide participation is achieved, coverage of chronic conditions substantially similar to Catamount Health.

(5) The agency shall determine whether it is cost-effective to the state to require the individual to purchase the approved employer-sponsored insurance plan with premium assistance under this subsection instead of Catamount Health established in section 4080f of Title 8 with assistance under subchapter 3a of chapter 19 of this title. If providing the individual with assistance to purchase Catamount Health is more cost-effective to the state than providing the individual with premium assistance to purchase the individual's approved employer-sponsored plan, the state shall provide the individual the option of purchasing Catamount Health with assistance for that product. An individual may purchase Catamount Health and receive Catamount Health assistance until the approved employer-sponsored plan has an open enrollment period, but the individual shall be required to enroll in the approved employer-sponsored plan in order to continue to receive any assistance. The agency shall not consider the medical history, medical conditions, or claims history of any individual for whom cost-effectiveness is being evaluated.

(6) Decisions regarding plan approval and cost-effectiveness are matters fully within the agency's discretion. On appeal pursuant to section 3091 of Title 3, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable. (emphasis added.)

W.A.M. § 5924.2 set out the criteria for whether an employer's plan (ESI) is comprehensive and affordable. The plan must cover prescription services. The plan must include appropriate coverage of chronic conditions once state participation in the blueprint for health is achieved. In addition, the plan's in-network deductible is not to exceed $500 for one person and $1,000 for two people or a family. In contrast with ESI, CHAP includes a number of co-payments with a maximum out-of-pocket expense of $800 for one person and $1,600 for a family for in-network services. Co-payments for medications do not count for the CHAP out-of-pocket maximums although there are limitations on the co-payments. The cost for medications under CHAP would be a fraction of the cost under the employer-sponsored health insurance offered by petitioner's employer.

Fair Hearing No. M-04/09-196

Fair Hearing No. M-04/09-196 raised similar issues to petitioner's case. In that case, the petitioner had Crohn's disease. The employer's plan included a $300 deductible and then covered 80 percent of the petitioner's medical costs up to a yearly out-of-pocket maximum of $3,000. In contrast, CHAP has a deductible of $250 and limits all other out-of-pocket expenses to $800 annually. In addition, the

Department would not provide wrap-around services because Crohn's disease was not on the list of chronic diseases used by the State as part of the blueprint for health.

In summary, the Board determined that:

> (1) there was no basis in the applicable statutes permitting the Department to include some chronic conditions and exclude others from wrap-around services.
>
> (2) the Department's policy of selecting certain chronic conditions for coverage was contrary to the intent of the statutes.
>
> (3) the Department did not follow the requirements of the Vermont Administrative Procedures Act (APA).
>
> (4) the Department's disparate treatment of individuals with chronic conditions violates the common benefits clause of the Vermont Constitution.

The Board's Order stated:

> If the petitioner remains enrolled in Catamount-ESI, or if the Department chooses to enroll him in CHAP, the Department shall pay all of the petitioner's cost sharing expenses related to his treatment and management of his Crohn's disease.

Pursuant to 3 V.S.A. § 3091(h), the Commissioner of the Agency of Human Services reversed the Board's Order. The discussion of petitioner's case below will address the

pertinent portions of Fair Hearing No. M-04/09-196 and the Commissioner's Reversal.[4]

Petitioner's Situation

Petitioner presents a similar case. She has a chronic condition. She needs costly medication. Her employer's medical insurance provides substantially less prescription coverage. Petitioner faces $6,500 in medication expenses.

If the wrap-around services are not available to petitioner, the cost of medications means her employer's plan is not substantially similar to CHAP. When a cost is prohibitive, the benefit is not necessarily available because the individual does not have the means to avail herself of the benefit. The cost prevents access. The loss of access makes the employer plan not comparable to CHAP. In the short-term, requiring the employer sponsored plan may be cost effective to the state. However, if medications are not available due to cost, results include not accessing needed medications leading to complications (higher medical costs) and possible loss of employment due to physical inability to handle work.

[4] This decision will not address the common benefits clause as there is no reason to reach the constitutional issue to decide this case. However, the Board stands by the analysis in Fair Hearing No. M-04/09-196.

The language above does not consider whether ulcerative colitis is a chronic condition subject to wrap-around services by OVHA. If OVHA provides wrap-around coverage for petitioner's ulcerative colitis, the employer sponsored plan is cost effective.

In Fair Hearing No. M-04/09-196, the Board discussed coverage of chronic conditions. The Department argued that Crohn's disease was not considered under chronic care coverage because it was not listed and that the Legislature intended to limit chronic care to the conditions listed in 33 V.S.A. § 1974(c)(1)(A) and 18 V.S.A. § 701(2).

There are a number of problems with this argument. First, 33 V.S.A. § 1974 needs to be read in conjunction with 33 V.S.A. § 1903a(b), which creates the "chronic care management program" and directs the administration to "provide a broad range of chronic conditions in the chronic care management program". Once again, these are remedial programs; remedial programs are to be liberally construed. The intent is to create a broad program given the monetary benefits of a coordinated approach to chronic care conditions.

Second, 18 V.S.A. § 701(2) defines chronic care as:

. . . health services provided by a health care

> professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to the highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. **Examples of chronic conditions** include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidenia. (emphasis added.)

The above definition mirrors the definition found in 33 V.S.A. § 1974(c)(1)(A). OVHA and the Department have read these definitions to mean that chronic care is limited to the examples in the statutes. Their interpretation is a misreading of the statutes. The examples are illustrative, not a limitation on the type of chronic conditions to be covered. If the Legislature meant to limit chronic care to certain conditions, the statutory language would say so. However, the Legislature did not do so.

Third, neither OVHA nor the Department has promulgated regulations to determine which chronic conditions are included in the "chronic care management" program. The failure to adopt regulations runs afoul of the Vermont APA. 3 V.S.A. §§ 831 *et seq*. In the Commissioner's Review of the earlier case, the Department stated that they had no obligation to do rule-making regarding chronic conditions. This view overlooks the overall statutory directive and due

process rationale for the Department and OVHA to do rule making of the eligibility, coverage, and termination conditions governing the health care programs under their purview.

The Legislature has set out the definition of chronic condition. Petitioner's ulcerative colitis meets the definition of a chronic condition. First, petitioner has a condition that meets the duration requirements. Second, petitioner needs ongoing treatment including medication to enable her to function and keep working, to minimize the effects of her condition, and to prevent complications. Ulcerative colitis is a chronic condition and should be treated similarly to those chronic conditions where OVHA provides wrap-around services.

The treatment of petitioner's chronic condition needs to be considered in light of the comparability of CHAP and the employer's insurance policy. The ultimate question is whether OVHA's decision regarding plan approval is arbitrary and unreasonable. 33 V.S.A. § 1974(c)(6).

The Legislature created the CHAP program to expand health coverage to uninsured individuals who are not eligible for Medicaid or VHAP and whose income is less than 300 percent of the FPL. CHAP is a remedial program. OVHA is

mandated to look at whether an employer's health insurance plan is substantially similar. Without wrap-around services for ulcerative colitis, the employer's plan is not substantially similar to CHAP.

In addition, the Legislature looked at chronic care. The Legislature understood the benefit of providing chronic care coverage since chronic care coverage can cut down on costly emergency care and the medical expenses caused by medical complications to an individual's health as well as providing individuals with sufficient medical care so they can maximize their ability to function including employment. The chronic care management program is intended to be inclusive and liberally applied.

OVHA's decision is considered an abuse of discretion and their decision is reversed. Whether OVHA chooses to keep petitioner in the ESIA program or to enroll petitioner in CHAP, OVHA will cover all of the petitioner's cost sharing expenses related to the treatment and management of her ulcerative colitis. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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